Public Health Association of Australia submission to the Review of South Australian Law and Practice

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Preamble

The Public Health Association of Australia

The Public Health Association of Australia (PHAA) is recognised as the principal non-government organisation for public health in Australia working to promote the health and well-being of all Australians. It is the pre-eminent voice for the public’s health in Australia.

The PHAA works to ensure that the public’s health is improved through sustained and determined efforts of the Board, the National Office, the State and Territory Branches, the Special Interest Groups and members.

The efforts of the PHAA are enhanced by our vision for a healthy Australia and by engaging with like-minded stakeholders in order to build coalitions of interest that influence public opinion, the media, political parties and governments.

Health is a human right, a vital resource for everyday life, and key factor in sustainability. Health equity and inequity do not exist in isolation from the conditions that underpin people’s health. The health status of all people is impacted by the social, cultural, political, environmental and economic determinants of health. Specific focus on these determinants is necessary to reduce the unfair and unjust effects of conditions of living that cause poor health and disease. These determinants underpin the strategic direction of the Association.

All members of the Association are committed to better health outcomes based on these principles.

Vision for a healthy population

A healthy region, a healthy nation, healthy people: living in an equitable society underpinned by a well-functioning ecosystem and a healthy environment, improving and promoting health for all.

The reduction of social and health inequities should be an over-arching goal of national policy and recognised as a key measure of our progress as a society. All public health activities and related government policy should be directed towards reducing social and health inequity nationally and, where possible, internationally.

Mission for the Public Health Association of Australia

As the leading national peak body for public health representation and advocacy, to drive better health outcomes through increased knowledge, better access and equity, evidence informed policy and effective population-based practice in public health.
Introduction

PHAA welcomes the opportunity to provide input to the Review of law and practice on abortion in South Australia.

PHAA has a well-established policy position statement on abortion. PHAA regards Abortion as a safe, common medical procedure which should be regulated in the same way as other medical procedures. Both medical and surgical abortions should be included in health service planning.

Universal access to safe, legal abortion services is essential to optimal reproductive health outcomes, including reducing maternal morbidity and mortality\(^1\), and is consistent with achieving the United Nations Sustainable Development Goals.\(^2\) Most Australians support women’s access to safe, legal abortion.\(^3, 4\)

Access to abortion services includes safe access without obstruction, abuse, intimidation or harassment interfering with the right to access legal abortion services. Safe access zones are needed to safeguard women’s human rights in relation to abortion and have an important role in ensuring privacy, safety and equality of access to healthcare for women in Australia.\(^5\) The constitutionality of state legislation providing for safe access zoning was upheld by the High Court in April 2019.\(^6\)

The provision of comprehensive abortion care and services should be guided by evidence-based strategies and plans at the nation and State/Territory level. In Australia, there are limited evidence-based guidelines and training to support the delivery of abortion services by skilled health professionals.

Abortion should be regulated in the same way as other health procedures, without additional barriers or conditions. The regulation of abortion should be removed from Australian criminal law.

States and Territories should actively work toward equitable access (including geographic and financial access) to abortion services, with a mix of public and private services available.

The PHAA specifically advocates for –

- The development of a comprehensive sexual and reproductive health strategy, addressing the domains identified in the Melbourne Proclamation.\(^7\)
- The removal of abortion from criminal codes in all states and territories and the treatment of abortion as a health issue in legislation and regulation.
- The availability of universally accessible comprehensive abortion care within public health services and international aid.
- Improved timely equitable access to safe medical and surgical abortion for Australian women, especially those experiencing disadvantage.
PHAA Response to the Review issues of interest

Role of the Criminal Law

1. Should there be offences relating to qualified health practitioners performing abortions in the Criminal Law Consolidation Act 1935 (SA)?

No. The regulation of abortion should be removed from criminal laws and codes of the states and territories and regulated under existing health care legislation.

Health professional practice should be regulated according to the Health Practitioner Regulation National Law Act 2009 and the Health Practitioner Regulation National Law (South Australia) Act 2010.

Qualified Health Practitioners should not be placed at risk of criminal sanctions for delivering health care.

Laws which criminalise and/or restrict abortion are not associated with lower abortion rates, but with higher maternal mortality and unsafe abortion rates.

The provision of termination services should be regulated the same as any other medical procedure of similar complexity. When performed by skilled providers using evidence-based medical techniques and medications, particularly if performed within the first 14 weeks of pregnancy, induced abortion is a safe medical procedure.

2. Should there be offences relating to the woman procuring an abortion in the Criminal Law Consolidation Act 1935 (SA)?

No. Abortion should not be in the criminal code but regulated like other health practices.

Women should not be placed at risk of criminal sanctions for obtaining health care. Women over the age of 16 should consent to undergoing an abortion as they would when receiving other health care procedure or medical treatment as per the Consent to Medical Treatment and Palliative Care Act 1995. Under current SA law a child under the age of 16 years should be able to provide his or her own consent for an abortion if the medical practitioner is of the opinion that the child understands the nature, consequences and risks of the proposed treatment.

3. Should a woman ever be criminally responsible for the termination of her own pregnancy?

No – as explained above.

4. Should South Australia have criminal offences for abortions not performed by an appropriate health practitioner?

No – as explained above. There should be no special law relating to terminations.

Who should be permitted to perform or assist in performing terminations

5. Should health practitioners (other than medical practitioners) be permitted to authorise or perform, or assist in performing, lawful terminations of pregnancy in South Australia?

Yes. Health practitioners other than medical practitioners may have a useful role to play in providing services in accordance with their expertise, and should not be prevented from doing so by special laws.

There is no case to treat the ordinary work of different health professions in unusual ways in regard to terminations.
There is strong evidence that other practitioners can provide safe, high quality abortion care and post abortion contraception abortion. The safety of early aspiration abortions performed by nurse practitioners, certified nurse midwives, and physician assistants has been found to be equivalent with those provided by physicians in America.

Research from Sweden shows that effectiveness of provision of medical abortion by nurse-midwife providers was superior to that provided by doctors and safety was equivalent. In this study women who had a consultation with a nurse-midwife were more likely to select this provider in the future if they were to seek a medical abortion. Medical abortion provided by nurse-midwives is more cost-effective than provision by physicians.

Shifting early induced medical abortion and vacuum aspiration abortion tasks to nurses and midwives also facilitates equitable and timely access to care and addresses geographical access challenges that promotes care that better serves women’s needs.

Pharmacists and health providers such as Aboriginal and Torres Strait Islander health workers and/or practitioners could play roles in specific components of care (eg, assessing gestational age and providing information on the appropriate use of drugs). Although provision of abortion care in later pregnancy remains a more specialised skill, facility-based non-physician health workers can play supportive roles—for example providing cervical priming before dilatation and evacuation or in caring for women in the interval between administration of medications and completion of the abortion process.

Workforce planning for abortion service provision should be undertaken on the basis of evidence-based guidance to inform the qualification and skill level for the most appropriate provider. Regulatory and service delivery developments relating to the provision of medical abortion presents an opportunity to improve geographic and economic access to early abortion.

Legislation and policy change is therefore required to allow these nurses, midwives and mid-level providers to perform early aspirations to expand access to abortion care.

Gestational Limits and Grounds for Termination of Pregnancy

6. Should a woman be allowed to access lawful abortion on request at any stage of a pregnancy?
Yes. Women should have full empowerment over their health in every respect. Decisions regarding an abortion should be made by a licenced health provider and a women.

The grounds for accessing abortion should not be limited by gestational age of the pregnancy. Barriers and restrictions to access, such as requirements for multiple opinions should not be applied through legislation, regulation or policy.

7. Should there be a gestational limit or limits for a lawful termination of pregnancy in South Australia?
No. Legal restrictions cause barriers to safe and timely abortion. These barriers may be particularly pronounced for young women and for women experiencing violence. Research has found that places where abortion is difficult to access are associated with higher maternal mortality and unsafe abortion rates.

Consistent with the above response.

8. If there is a gestational limit for a lawful termination should it be related to:
   (a) the first trimester of pregnancy;
   (b) viability of the foetus (approximately 22 – 24 weeks);
   (c) other?
None of the above.

9. Should there be a specific ground or grounds for a lawful termination of pregnancy?
No.

10. If there is a specific ground or grounds for a lawful termination should they include:
(a) all relevant medical circumstances;
(b) professional standards and guidelines;
(c) that it is necessary to preserve the life of the woman;
(d) that it is necessary to protect the physical or mental health of the woman;
(e) that it is necessary or appropriate having regard to the woman’s social or economic circumstances;
(f) that the pregnancy is the result of rape or another coerced or unlawful act;
(g) that there is a risk of serious or fatal foetal abnormality (drawing on the terminology from the present law).

There should be no specific grounds required, so none of the above issues are applicable.

11. Should different considerations apply at different stages of pregnancy?
No. Abortion should be regulated in the same way as other health procedures, without additional barriers or conditions. Barriers and restrictions to access, such as requirements for multiple opinions, should not be applied through legislation, regulation or policy.

Consultation by the medical practitioner

12. Should a medical practitioner be required to consult with one or more others (such as another medical practitioner or health practitioner), before performing a termination of pregnancy?
No. There should be no special requirements on practitioners on the provision of ordinary medical advice and care relating to terminations. A medical practitioner or another health professional providing abortion services should not be compelled by the law to consult with another provider.
An abortion provider should consult with other professionals on the basis of their clinical view that a women requires expert referral to a medical specialist, psychologist or social worker.

13. If a consultation is required, should it include:
(a) another medical practitioner; or
(b) a specialist obstetrician or gynaecologist; or
(c) a health practitioner whose specialty is relevant to the circumstances of the case; or
(d) referral to an appropriate counsellor; or
(e) referral to a specialist committee?
Consultation should not be necessary, and therefore none of the above issues are applicable.

14. If there was a referral requirement should it apply:
(a) for all terminations, except in an emergency;
No. This would be the equivalent of the current law; compounding other barriers to access including inability to pay, lack of social support, delays in seeking health care, providers’ negative attitudes, poor quality services and a lack of policy and resources to ensure adequate service provision. These barriers largely affect adolescents and women who are from ethno-cultural minorities, low income, rural or remote living and experience violence and/or abuse.¹¹³

(b) for terminations to be performed after a relevant gestational limit or on specific grounds?

No. There are high quality evidence-based guidelines to support abortion service delivery.¹⁴

**Conscientious objection**

15. *Should there be provision for health practitioners in South Australia to decline to provide an abortion related service for conscientious objection?*

Yes. However clear referral protocols must be demonstrated in the case of general practice and other providers identified within a 5kms radius from this provider. The WHO guidelines for developing countries recommend monitoring the health status of those who live further than 5 km from a health facility.¹⁵

In public facilities other professionals must be available to provide abortion. Where there are no providers or in the case of an emergency as per below professionals must deliver abortion care. Health professionals must register their conscious objection and this must be communicated to women in materials about the private practice. Conscious objection must not be on the basis of age, gender, ethnicity or social economic status. Denying a women an abortion increase anxiety.¹⁶

16. *If a medical practitioner had a conscientious objection are there circumstances where this objection should be overridden, such as:*

   (a) in an emergency;
   
   (b) the absence of another health practitioner or termination of pregnancy service within a reasonable geographic proximity.

Yes, conscious objection should be overridden in both the examples given. Health provider education and continuous professional development programs should emphasis this in abortion sensitivity training.

17. *Should a health practitioner who has a conscientious objection be obliged to refer or direct a woman to another practitioner or termination of pregnancy service?*

Health professionals with a conscientious objection to abortion care should inform their patients and refer patients to another health professional without such objection. Registration, professional and educational bodies should reinforce this responsibility.

**Counselling**

18. *Should there be any requirements in relation to offering counselling for the woman?*

No. There is no evidence that routine counselling is effective in preventing subsequent abortions.¹⁷,¹⁸ However contraception counselling particularly for LARC should be offered as optional. Health professionals should be given sensitivity training to assist them to recognise the need for such counselling.¹⁹

Barriers and restrictions to access, such as requirements for mandated counselling should not be applied through legislation, regulation or policy.

Abortion service providers should offer optional, comprehensive pre and post-abortion counselling.
Protection of women and service providers and safe access zones

In regard to safe access zones, the Victorian legislation is currently the most comprehensive in Australia, prohibiting:

- besetting, harassing, intimidating, interfering with, threatening, hindering, impeding or obstructing a person attempting to access the premises;
- communicating by any means in relation to abortions in a manner that is able to be seen or heard by a person attempting to access the premises and which is reasonably likely to cause distress or anxiety;
- interfering with or impeding a footpath, road or vehicle; intentionally recording by any means another person attempting to access the premises;
- intentionally recording by any means, without reasonable excuse, another person attempting to access the premises, without that person’s consent.

The law in South Australia should be reformed to follow the Victorian legislation.

19. **Should South Australia provide for safe access zones in the area around premises where termination of pregnancy services are provided?**

Yes. Legal protection should safeguard clients and staff of legal abortion services from harassment. This should include the provision of exclusion zones. This is consistent with the law in Queensland, NSW, ACT, Tasmania, NT, and Victoria, and similar reform is also under consideration in West Australia.

20. **If a safe access zone was established should it:**

   (a) automatically establish an area around the premises as a safe access zone?

   Yes.

   *or*

   (b) empower the responsible Minister to make a declaration establishing the area of each safe access zone?

   No - it should be automatic around every service that provides so that there are no exceptions and all women seeking an abortion are included.

The establishment of safe access zones should not be left to ministerial discretion, noting that ministers inevitable have personal views of their own, or are subject to political pressure, which may interfere with the provision of appropriate protection to women seeking to safely access lawful services.

21. **What types of behaviour or conduct should be prohibited in a safe access zone?**

Harassment of any kind should be prohibited. A safe zone should prohibits threatening, intimidating or harassing behaviour within 150m of abortion provider premises. This includes filming and distributing photographs or video of people accessing the premises.

22. **Should the prohibition on behaviours in a safe access zone apply only during periods of operation?**

Protection should apply to women in respect of every aspect of their access to such services.

Protections should apply at all times. Protection should not be inapplicable due merely to factors such as clinics not yet being opened for the day, or just after closing time, or for other periods of closure during the day. The concept of ‘periods of operation’ is unnecessary and might potentially be misused to evade the intended application of protective safe access laws.
23. Should it be an offence in South Australia to make or publish a recording of another person entering or leaving, or trying to enter or leave, premises where termination of pregnancy services are performed, unless the recorded person has given their consent?

Yes. Such activities are highly likely to amount to harassment.

24. Should it be unlawful to harass, intimidate or obstruct:

(a) a woman who is considering, or who has undergone, a termination of pregnancy;
(b) a person who performs or assists, or who has performed or assisted in performing, a lawful termination of pregnancy?

Yes.

Collection of data about terminations of pregnancy

25. Should data about terminations of pregnancy in South Australia be reportable?

Yes. Data collection is useful for many public health and policy-making purposes. High quality comprehensive data about abortion in SA should be collected.

Limited national surveillance of abortion in Australia is a major public health challenge which adversely impacts upon the ability of National, State and Territory governments to monitor health outcomes of priority populations and plan and evaluate reproductive health policy and services. Only three jurisdictions (Northern Territory, South Australia and Western Australia) have reporting requirements for induced surgical and medical abortion. Medicare data has been used nationally as a proxy for abortion however, this data lacks specificity and sensitivities for early pregnancy, surgical abortions and for medical abortion.

Such data should, however, be appropriately depersonalised to ensure privacy of individuals.

Rural and Regional Access

26. Given the difficulties of access to medical services in rural areas of South Australia should there be different laws to facilitate access in rural and regional areas?

All women must have universal access to abortion services as they should maternal care and other aspects of reproductive health. Abortion should be part of comprehensive sexual and reproductive health care. Abortion services should be included in service planning for all state and territory health authorities and delivered in accordance with evidence-based standards of best practice and informed consent.

State and territory health systems should plan and ensure the provision of services to all Australians regardless of place of residence. Wherever necessary special arrangements for rural and regional areas should be made as part of ordinary system planning to provide equity to people in all geographical areas.

27. Should women be permitted to use telehealth or other electronic services to consult with medical and/or health practitioners?

Yes. Telemedicine for abortion is safe, expands access to abortion and is cost effective in Australia and the US.
28. Where a woman would otherwise be able to have a termination but does not have local access to clinics able to do so (such as in rural South Australia), should another qualified health practitioner (such as a registered nurse or pharmacist) be permitted to undertake this procedure.

Yes, if appropriate and consistent with requirements for metropolitan locations – appropriately qualified and regulated. This is a matter for detailed health service delivery planning that recognises and addresses resourcing and staffing limitations in rural and regional areas.

**Incidental**

29. Should there be a residency requirement to access a lawful abortion in South Australia?

No. Abortion should be universally accessible in every state and territory as with all other health care.

30. Do you have any suggestions for incidental law changes to present law and/or practice in South Australia in relation to abortion?

No. Termination should be removed entirely from the domain of criminal law.

31. Are there any other comments you would like to make in relation to this reference?

South Australia is falling behind developments in other jurisdictions to protect the rights of women and the provision of safe, accessible services to them. The Review is timely and should proceed quickly to modernise the situation in South Australia.

The Review should also note that the only other state yet to implement safe access protection – Western Australia – is currently developing reforms to do so.

**Conclusion**

The PHAA appreciates the opportunity to make this submission. Please do not hesitate to contact me should you require additional information or have any queries in relation to this submission.

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References


